GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF INTENT TO BECOME A PARTY OF INTEREST

Instructions: Any group insurance company or other disability benefits provider who has made payments in the employee's behalf for disability benefits pursuant to an employer paid plan, and who wishes to be named a party of interest to obtain reimbursement for those expenses which have been paid, shall file this form with the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address	
Employee E-mail			
EMPLOYER	Name	**INSURER/ SELF INSURER**	Name
Address		**CLAIMS OFFICE**	Name
		Address	
Employer E-mail		Claims E-mail	

B. NOTICE

Notice is hereby given that: _____
(Print Name of provider)

Address	Phone
	E-mail

has made payments in the amount of $ _____ on the employee's behalf for disability benefits and desires to be made a party at interest in this claim for reimbursement for funds so expended, should liability be established under Title 34-9.

C. CERTIFICATION

❑ I hereby certify that I have sent a copy of this form to all parties and counsel in this claim, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

Print Name Here	Signature	Date

Phone	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).